Review of Prevention with Positives

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Why prevention with/for positives?

- People living longer, feeling better, more likely to engage in sexual activity
- Increases in risk behaviours in some groups in some settings (e.g. MSM)
- Probably more cost-effective, smaller pool of people

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Good news and bad news

- WHO convened a consensus meeting and will be publishing prevention with positives guidelines in Jan 2007
- Very little evidence from resource constrained settings, most research taking place in US and with specific populations such as MSM or IDU

Sneak Preview: New Guidelines

- Behavioural prevention
  - Psychosocial support e.g. mental health services, active referral
  - Disclosure and partner notification
  - Family planning for HIV positive people
  - Needle exchange and opiate substitution therapy

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New Guidelines continued

- Treatment and care
  - Safe water
  - TB
  - Acyclovir
  - Azoles (Fluconazole)
  - Malaria
  - STI
  - Vaccines (Hep B, pneumococal, influenza)

Providing more options

- Example of family planning - often one-size-fits-all programmes
- Focus on ease of delivery
- Shift to providing variety of choices, evidence for women making better FP choices for themselves than health workers

Ongoing research

- Primarily focused on individuals or small groups
- Motivational interviewing (Golin) - helping people articulate their own reasons for behaviour change
- Menu-based (Mayer) - modules for patients' to choose from (depression, substance use)

Ongoing research

- Weekend prevention roadshows (Rosser) - participants attend 2-day risk reduction weekend
- Cognitive behavioural stress management (Tobin/Weiss) - small groups of women, African American or latina

Major gaps

- International intervention research for high prevalence settings
- Testing interventions at structural or system levels
- Long term maintenance of prevention interventions, issues of fatigue
- Looking at how practices are adopted e.g. serosorting, ‘strategic positioning’

Current work in SA

- Fisher's Options project - US model was clinician delivered, 'prescription for behaviour change'
- Adaptation for SA, KZN - counselor delivered, brief but at every clinical encounter, incorporates information, motivation, behavioural skills
- Rapid assessment - does client need support around motivation or information?

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Programmatic options in SA

- Using every clinical interaction as an opportunity for communicating meaningful prevention messages
- Active case finding for STI with simple, standardised questions
  - Have you had any discharge, genital sores, ulcers or burning pain on urination?

Provider Communication Styles

Advantages

Using condoms can help keep you free from STIs.

Consequences

Not using condoms puts you at risk for getting STIs.

Richardson, Partnership for Health

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Evidence based prevention

- Using proven interventions and adapting them to local contexts
- Routinizing P4P into clinical care and mental health services
- Training appropriate health workers in delivering prevention messages and counseling => testing efficacy

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Resources

- October 2004 special supplement to JAIDS - most issues are still very relevant
- Golin - motivational interviewing and P4P
- Fisher - Options project


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